Letters to a Young Doctor

Evaluating preregistration posts

PHILIP RHODES

Regions of the National Health Service vary in their practices, but I shall describe a typical scheme of evaluating posts for the preregistration year. Every three or four years the site of the preregistration posts is visited by the dean of the faculty of medicine or the postgraduate dean and one or two others. They inspect the facilities of the hospitals and units where the posts are offered and interview the consultants who are in charge of the posts, those who hold the posts, and, when necessary, administrators. By visiting every few years, all the posts in the region are covered sufficiently frequently. The visiting team checks on such things as the experience that the house officer has gained—knowing the numbers of staff in different grades, the numbers of beds on the unit concerned, and what outpatient facilities there are all help; the support services and the adequacy of pathology, radiotherapy, physiotherapy services and so on; library services; catering (especially at night); and accommodation. Bare statistics are fleshed out by inspecting bedrooms, commonrooms, kitchens, dining rooms, laboratories, libraries, and the postgraduate medical centre, and by the personal interviews.

There is great variability among posts, of course, so that there can be no standard ideal pattern of experience. Nevertheless, the visiting team can get an impression of the value of a post and its purposes from all these data, even though the data may not be strictly measurable. If some aspects of the post seem to be unsuitable and could be improved the visitors take these up with consultants and administrators. It is then left to the latter two to bring about the improvements recommended, but the final sanction to make them do so rests with the preregistration house officer committee, which oversees the preregistration year for the faculty of medicine and can withdraw approval from the post and then the post can no longer be filled.

In addition to the visits a postal questionnaire is sent out every six months to all preregistration house officers in the region (about 150 to 200). This has a checklist for the incumbent to complete about the post. These returns are very valuable, for they show whether the doctors who hold the posts think that they are worth while. After a few years the dean knows which posts are uniformly good and which are indifferent or bad, and this can be used as a basis for action in visiting, for bringing pressure to bear for improvement, or for withdrawing educational approval. One bad report from a dissatisfied incumbent is not enough to put the machinery in motion, but if there are continuous reports of dissatisfaction then the machinery is called into action.

Furthermore, each consultant who is in charge of a preregistration house officer prepares a report at the end of six months about the house officer's ability to take a history and examine patients, his punctuality, knowledge, rapport with patients, relatives, and nurses, his ability to present cases, and so on. If the report is not good the house officer may need advice about himself and his behaviour. The advice is given by the dean, but it is rarely necessary and is meant to be helpful and not in any way punitive. There may be personality clashes between a particular consultant and his house officer, and it is recognised that the younger doctor is not always at fault, so that any action is taken reluctantly and circumspectly, and with due consideration of all the factors.

Some preregistration house officer posts are better than others, which is inevitable. Resources, practice, consultants, and other medical staff vary so. The dean attempts to make consultants aware of their educational duties towards their house officers. Some accept these and are conscientious, while others are more reluctant. The same is true of teachers everywhere, and although direction from the centre may be enlightened, local interpretation of what is wanted may frustrate it.

Which post to apply for?

In every region there is a list of all the preregistration house officer posts available in the region in the dean's office or with the postgraduate dean. It is of little use simply to consult this list before you have made up your mind roughly what you want to do and where you want to go. Perhaps the first decision is whether you wish to do medicine or surgery first. Some intending physicians like to get surgery out of the way quickly. Intending surgeons may feel the same about medicine. Some who are not sure what they ultimately want to do might wish to sample surgery, say, before deciding whether that is really what they want to do. The order in which these first two jobs are done does not really matter.

A lot of anxiety is generated by wondering just how important it is to have a post at one's own teaching hospital. This is difficult to estimate, but is much less important than it used to be. Under the National Health Service the quality of district general hospitals has so improved and the experience and teaching they give is often comparable with, or even better than, that in a teaching hospital. Teaching hospitals have properly and naturally become more and more specialised. They tend to be referral centres for patients with esoteric disorders and are often consulted by other consultants. This restricts the range of patients seen, especially on units dealing with only one sort of case, such as cardiology, endocrinology, respiratory medicine, and so on. On the other hand, in district general hospitals, where there are fewer consultant staff to each discipline, each unit has to take all that comes and thus these hospitals are often more general than the teaching hospitals. This is not always true, however, since there are many general units in teaching hospitals, and many specialised units in district general hospitals.

University of Southampton, Southampton

PHILIP RHODES, MB, FRCS, professor of postgraduate medical education, and dean of graduate medicine for the Wessex region

Only by investigating personally will you learn about specific posts. The best source of information is undoubtedly a person who has recently held the post, but recognise that we all tend to gloss over the difficulties that we may have had so that we may not diminish the experience in our own eyes.

Having narrowed down the number of posts in which you may be interested, perhaps by having worked as a student in a district general hospital, go to see the consultants concerned with the post, unless you are already well known to them. There is nothing like this personal approach. Consultants see hundreds of people a year. They cannot remember all of them, certainly not their names. If they do remember a name they may in memory attribute it to the wrong person. Photographs are a bit of a help, but beards and hairstyles change, students mature, and though you may see the likeness and the continuity in yourself over a few years others may not. A consultant may have impressed you when you worked on his firm, but you may not have impressed him. Beyond this, a visit shows that you really are interested in that particular post, and it is a courtesy

to see the persons with whom you may be working for six months or more.

When you go, consider carefully what you wear and how you look. Most consultants like their junior colleagues to look and behave like the conventional image of a doctor. So do patients. And you will have realised that most patients in hospitals are over the age of 65 and probably have an image of a doctor that does not accord with youth's culture. You need to show that you are sensitive to these different attitudes. Your working life is with those who are older—often much older—than you. Rapport must be established with them so that you may use your personality to best effect for them. The first judgment of personality comes from outward appearances and the impressions they make on the beholder. You may feel that this is to be deplored, but it is important to live in the real world and so recognise the strength of views that may be more widely held than your own.

In the next article I will discuss how to go about getting a post as a preregistration house officer.

Can idiopathic hypertension cause unsteadiness when a person gets up?

Unsteadiness or dizziness occurs commonly in healthy subjects,¹ particularly on assuming the erect position from a warm bed or after squatting, when the normal orthostatic increase in venous return may fail. It is also a common symptom in subjects with essential hypertension, but its occurrence is only more frequent than in normal subjects in patients with high diastolic pressures or evidence of end organ disease such as retinopathy.² Although this symptom is considered by doctors to be more common in hypertensive patients, it is equally common in patients who are normotensive and whose blood pressures have been measured, and less common in patients attending the clinic and whose blood pressures have not been recorded.¹ This presumably reflects the historical association of dizziness and hypertension³ so that patients with this symptom are more likely to have their blood pressure recorded. Another possible cause of dizziness or unsteadiness on standing is persistent postural hypotension, which may be distinguished by measuring blood pressure lying and standing. This has many causes including peripheral neuropathy affecting the autonomic nervous system due to systemic diseases such as diabetes, alcoholism, or amyloid disease, all of which may be associated with hypertension. In such cases there is an associated loss of cholinergic as well as adrenergic function, and symptoms of anhidrosis and constipation may occur. A more frequent cause of postural hypotension in patients with essential hypertension, however, is the use of post-ganglionic blocking drugs such as debrisoquine, bethanidine, and, particularly, guanethidine, which prevent the normal baro-reflex mediated increase in peripheral resistance required to maintain blood pressure in the erect position. Thus dizziness on standing in patients with hypertension may be a benign symptom similar to that which occurs in many normal individuals or it may be due to persistent postural hypotension secondary to drug treatment or underlying neurological disease.—**DESMOND FITZGERALD**, research registrar, **EOIN T O'BRIEN**, consultant physician, cardiology, Dublin.

¹ Robinson JO. Symptoms and the discovery of high blood pressure. *J Psychosom Res* 1969;13:157-61.

² Weiss NS. Relation of high blood pressure to headache, epistaxis and selected other symptoms. *N Engl J Med* 1972;287:631-3.

³ Janeway TC. A clinical study of hypertensive cardiovascular disease. *Arch Intern Med* 1913;12:755-97.

How common is sensitivity to fluorescent lights?

Presumably "sensitivity" is intended to mean something adverse or negative. There is no easy answer. "So many people" is an inaccurate statistic, but that intermittent illumination can be irritating is well known. There is no reason why defective fluorescent tubes should be tolerated even though they are unlikely to cause organic harm. The relation postulated to epilepsy is unlikely to be valid: epileptic fits tend to be evoked by frequencies (≈ 10 Hz) low as compared with AC intermittency (100 Hz). DC tubes would be costly and carry

other risks. Sensitivity to intermittency has been studied both seriously¹ and otherwise.—**R A WEALE**, professor of visual science, London.

¹ Collins JB. Influence of characteristics of fluctuating visual stimulus on flicker sensation. *Ophthalmologica* 1956;131:83-104.

What are the possible health hazards associated with the domestic use of urea formaldehyde cavity wall filling? Is this substance known to be toxic or even carcinogenic after long-term use?

There have been several recent reviews of formaldehyde toxicity.¹ In addition to its domestic use for cavity wall insulation, urea formaldehyde has been used in the manufacture of plywood and chipboard, which are used in home construction. The same resin produces wrinkle-free, crease-resistant textiles. In the presence of moisture, and maybe heat, urea formaldehyde may decompose back into its constituents. Thus people may be exposed to low levels of formaldehyde over long periods. The odour of formaldehyde may be detected at 0.05 ppm and eye irritation, lachrymation, and upper respiratory tract irritation have been reported at this concentration. Sensitivity reactions to formaldehyde vapour include asthma and mild persistent symptoms of upper respiratory tract irritation. Occupational asthma due to formaldehyde, although uncommon, is fairly well established,² but there could be a threshold concentration below which it does not occur (or is extremely unlikely). On the other hand, some individuals, on chronic exposure to very low concentrations, develop symptoms that include breathlessness, headache, rhinitis, eye irritation, cough, colds, rash, and malaise. Although some investigations are under way in the United Kingdom, the effects have been largely studied in North America. There, several reports relate to people living in "trailer homes" or houses with chipboard walls and the United States Consumer Product Safety Commission has recently issued a rule banning urea formaldehyde foam insulation in residences and schools.³ It has been argued that the inner leaves of British cavity walls are thicker and plastered. But how thick must a wall be to provide protection? What if the plaster is cracked or broken through for a pipe run? What of dormer bedrooms in bungalows higher than the top of outside cavity walls? There are many questions still unanswered. Formaldehyde is known to be a mutagen and has been reported to produce nasal cancers in rats. It has not, however, been shown to be a human carcinogen. On general grounds one would expect to find clearest evidence of cancer in man in the chemical industry where formaldehyde is produced, but so far none has been found.⁴ Cavity wall insulation with urea formaldehyde has not been used long enough for any useful studies to be undertaken of carcinogenesis under these circumstances.—**W R LEE**, professor of occupational health, Manchester.

¹ Anonymous. The health hazards of formaldehyde. *Lancet* 1981;i:926-7.

² Hendrick DJ, Lane DJ. Occupational formalin asthma. *Br J Ind Med* 1977;34:11-8.

³ Federal Register 47(64):14366-419, 1982.

⁴ Bryson DD. Health hazards of formaldehyde. *Lancet* 1981;i:1263-4.